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July 25, 2005

Cynthia L. O'Donnell, Esquire
Tighe, Evan, Schenck & Paras
Four Gateway Center
444 Liberty Avenue, Suite 1300
Pittsburgh, PA 15222-1223

RE: **DAVID BIEBEL**
SS#: 171-34-8116
TIME: 2:30 PM
OFFICE: Seven Fields
AREA: Right Knee, Cervical Spine and Lumbosacral Spine

Dear Ms. O'Donnell:

I had the opportunity to see and examine Mr. David Biebel on July 25, 2005 for the purpose of an Independent Medical Evaluation for alleged injuries incurred during a fall while at Kohl's. This was on June 29, 2004.

HISTORY: Mr. Biebel states he lives in Erie, PA, was born in 1944 and relates extensive past medical history of multiple problems other than his right knee. Specifically, he states he was on workers' compensation related to a left knee injury for a work-related injury he relates back to early 2001. He also admits upon questioning, lower back and neck issues in the past. His original injury to his left knee occurred when stepping into a two-foot hole while in a parking area.

He states that he has been on Social Security disability after his injury in 2001 and also he receives workers' compensation for his left knee. He describes the inability to "do anything physical since 2001" at the time of his injury in Kohl's. Specifically he states he has not been able to golf, play sports, bicycle, and has been using a cane routinely. He did minimal housework, minimal driving and minimal activities of daily living.

He states that at the time of his injury on June 29, 2004 he was utilizing a cane and walking with some pain and weakness that he admitted to in the left knee. Specifically he described having to have a left knee replacement

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after his 2001 injury and ultimately due to failure of such having to have a revision left knee replacement on August 29, 2002, approximately ten months prior.

At the time of his injury in Kohl's he was still utilizing a cane, was still under active care with Dr. Fessler, and described ongoing weakness.

Mr. Biebel described to me walking into Kohl's Department Store using his cane. He states that in the men's department he picked up some shirts, pants and socks and various items and had his cane in his right hand. He states that he was looking for the shoe department and states that in his opinion a shoe measuring device was in the middle of the floor, he struck it with his left foot, and he states that he tried to catch himself but fell, hit his head, did not pass out, twisted to his right and hit the front of his right knee. He described a cracking sensation and discomfort. He states he was transported via an ambulance to Hamot emergency room where he had evaluation of his right knee and his cervical spine and back.

He describes being seen in the emergency room, treated and released. He was not admitted to the hospital. He states that he came under the care mainly of Dr. Nick Stefanovski. He does admit that he had been under the prior care of pain management for quite some time and admitted that he had been seen prior to that time by HealthSouth Pain Management Systems and specifically had received a relative multitude of treatments on his back and neck, including lumbar epidural injections multiple times, SI joint injections, and various other pain management.

He ultimately was seen and evaluated by Dr. Nick Stefanovski, an orthopedic surgeon. He states that Dr. Stefanovski evaluated him shortly after his injury, mainly for his right knee, felt he had a meniscus tear and obtained an MRI. He was told that he had a meniscus tear and therefore on August 13, 2004, relatively acutely, underwent surgery. He recalls being told that he had a right knee that was "exactly like the left knee". He states that he was told that he may need "similar treatment" ,i.e. knee replacement. Over time he was followed by Dr. Stefanovski and is still under his care. He recalls being scheduled to start right knee viscosupplementation (aka Synvisc) on August 2nd.

Presently he denies any pre existing problems with his right knee in the past. He states that his right knee surgery has not really helped his knee to any great degree. At this juncture he states that he continues to use a cane, continues to take hydrocodone, but states that the main difference in his utilization of pain medication before and after the fall at Kohl's was that "I had to go from 7.5 mg hydrocodone to 10 mg". He admits to chronic pre existent significant pain requiring hydrocodone prior to his fall at Kohl's, states that he receives "blocks in his low back six times a year." That treatment was established after 2001. He also feels that his cervical spine was injured and is now "killing me". He denies numbness, tingling or neurological symptoms that have changed after the 2004 injury.

Regarding the right knee, he again denies a prior history and describes pain and discomfort over the anterolateral knee. He states that it is present most of the time. He states he has some light numbness into his right foot on the dorsal surface intermittently and also some pain down the front of his leg on the pretibial border. He states that he has had no new significant testing, therapy or associated activities recently. He admits that he continues to walk with pain. Now he states it is for both knees verses just one. He feels weaker 2ndary to pain .

At this juncture he states that he is contemplating a total knee arthroplasty on the right.

He has not had any specific cervical treatment different than what he had beforehand, just feels that he takes more medicine and has more pain. That would be his recollection of the significant difference.

PHYSICAL EXAMINATION: On clinical examination, watching this patient stand up, he walks with a cane, he did get out of a chair without it though, which was somewhat unusual. He has a slight varus thrust to the right. He has a left total knee arthroplasty incision. He walks slowly with an exaggerated antalgic gait to the right. When I asked him to show me his main spot of pain, he clearly and repetitively points to the tibial tubercle outside the knee joint as "the real hotspot". He describes pain there and severely down the tibia more than the knee. Clinical examination shows no gross atrophy of the right knee. There is no effusion. He is not hot to touch and is not warm to touch and actually has a relatively benign knee examination from that standpoint. He has good stability to the ACL with a negative Lachman's, negative pivot shift, negative posterior drawer and a negative anterior drawer. He has stable collaterals when tested to 0 and 30. He has no varus or valgus opening, instability or laxity. He has good end point on both. He has no rotational instability. Examination shows him to have range to full 0 degrees, flexion to 130 degrees with pain past 30 degrees and verbalized discomfort on any range of motion, but despite that has minimal crepitation. There seemed to be trace crepitation along the anteromedial joint more than anywhere. He has generalized pain to light touch over multiple areas of the knee, despite no heat, warmth or punctate findings. I could not isolate specific medial or lateral joint line pain, or patellofemoral pain. The Q-angle is normal. Patella tilt is negative. Straight leg raising when tested bilaterally is without lag. There is no VMO or quad atrophy noted and overall the patient has evidence of punctate to generalized soft tissue pain in his knee with a slight varus deformity and slight varus stress on gait.

I did examine also his lumbosacral spine. He can forward flex to 90 degrees but groans loud as soon as he starts at all, and describes midlumbar pain with all activities of any motion. He has exaggerated pain to axial load compression of his head and to pelvic tilt. He describes the pain as 10 on a scale of 10 with most things I do. Interesting enough, when he flexes to 90 degrees he describes a burning pain down his legs when he is standing, when he does this seated and I actually bring his leg up seated he has no pain whatsoever, including with dorsiflexion of his foot, no low back pain, no buttocks pain, no radicular symptoms. Reflexes are intact, brisk, but equal side to side. He again has moderate pain to light touch and has no evidence of spasm, no

evidence of kyphosis, lordosis or extensive scoliosis. Straight leg raise is 20 degrees on the right and 40 degrees on the left with pain, but no radicular symptoms. He has no atrophy noted, no long track signs. In a seated position I straightened his leg and dorsiflexed him three times without complaints of any back pain. He has a negative Spurling's. He had no deformity or localized objective findings. He has brisk quadriceps reflex, slightly decreased left ankle verses right, but a very reasonable reflex.

Cervical examination shows no deformity, no torticollis, no stepoff, no scoliosis, no muscular spasm, no heat, no warmth, no swelling and no atrophy of the cervical musculature. Flexion is chin to chest, extension is 30 degrees, lateral rotation is 35 degrees, and lateral bending is 30 degrees. There are brisk reflexes in the biceps, triceps, brachioradialis; no atrophy of the hands. There is intact sensation and pain distally. He complains of arm numbness with extension in a nonfocal distribution. He has a negative Spurling's test.

DIAGNOSTIC REVIEW: Today x-rays of the right knee were done bilateral weightbearing. He has a left total knee arthroplasty revision in reasonable position and alignment. Right side weightbearing shows moderate medial degenerative joint disease, slightly greater patellofemoral arthrosis. Lateral joint is intact.

Multiple other diagnostic films are available to review. I specifically was able to review films sent to me today in two separate packets. These films include bilateral knee x-rays after his injury from Renaissance Orthopedics showing intact patellofemoral joint and a reasonable total knee arthroplasty. The films from Renaissance Orthopedics at this juncture do show some mild right medial narrowing, but not significant narrowing at that point. The lateral view of the knee looks reasonable.

I was also sent and reviewed additional diagnostic films on Mr. Biebel which included multiple MR scans. A right knee MRI from July 1, 2004 was available for review. This documented notably that the patient had no acute fractures, no bone contusions or changes. Notable is that on that MRI, which is two days post injury, there was noted low grade tibial-femoral degenerative joint disease, which was found at surgery. The patient had a Baker's cyst, which is consistent with chronic degenerative meniscal tearing, later found at surgery (surgical findings diagnosed degenerative meniscus tear). Baker's cyst is consistent with degenerative joint disease and degenerative meniscal findings.

Additionally available for review were the patient's cervical and lumbosacral spine films from July 14, 2004. I was able to review these in total. Cervical spine July 14, 2004 documented degenerative spondylosis and no acute findings. Notable is that the MRI of the lumbosacral spine likewise showed significant degenerative disc disease at L4-5, L5-S1; no specific herniation and in my opinion some mild narrowing.

RECORD REVIEW: Available for review are extensive records on Mr. Biebel as listed. The records listed below were reviewed:

1. Emergency department records from Hamot Medical Center, dated 10/23/87, 10/24/87, 8/3/98, 8/4/98 and 6/29/04
2. Office notes by Dr. Thomas Fessler, dated 5/29/01 through 7/23/03, including operative reports dated 6/1/01, 3/11/02 and 8/29/02
3. Independent Medical Evaluation report by Dr. Donald Viscusi, dated 8/30/01
4. Office note by Dr. George Hochreiter, dated 3/7/02
5. Independent Medical Evaluation by Dr. Michael Jurenovich, dated 7/15/03
6. Independent Medical Evaluation by Dr. Michael Seel, dated 2/17/04
7. Office notes by Dr. Nick Stefanovski, dated 7/1/04 through 4/26/05, including an operative report dated 8/13/04
8. PCP notes, dated 1/2/73 through 5/4/02
9. Admission records from St. Vincent records, dated 3/11/02 through 3/14/02
10. Office notes by Dr. Jithendra Rai, dated 4/14/03 through 5/4/05
11. Office notes initialed LLS, dated 7/1/04 through 8/5/04
12. Physical therapy notes, dated 7/2/01 through 7/20/01, 8/7/01 through 10/10/01, 4/2/02 through 7/19/02, 12/9/02 through 12/13/02, and 1/13/03 through 3/24/03
13. Miscellaneous

Emergency room record from Hamot dated June 29, 2004. Fall on right knee while at Kohl's with complaints of pain in the neck, hip area and right knee. Neck examination shows paraspinous tenderness. Notable is that extremity examination showed tenderness over the right hand and right knee. Notable is there was no effusion or fluid. The patient had no documented instability, no restricted motion or weakness. The patient had negative thoracic, lumbar and sacral spine examination. X-rays were felt to be normal. The patient was diagnosed with a cervical sprain, right knee and hip pain.

Additionally reviewed were multiple diagnostic study reports: Cervical spine from August 2, 2001 showing spondylitic changes, disc space narrowing, no fractures (report only) from Hamot Health Foundation.

Cervical spine MRI from August 2, 2001, report only, documents no cord lesion, neuroforaminal narrowing due to facet arthrosis/degenerative joint disease and uncinate degenerative joint disease.

Lumbar spine MRI from August 2, 2001 documents disc bulge, loss of disc height L5-S1.

Lumbosacral MRI from January 14, 2003 documents low back pain as the complaint. Severe degenerative disc disease L4-5, L5-S1; no disc bulges or herniations. Normal neuroforaminal narrowing.

C-spine from June 29, 2004 documents advanced degenerative spondylosis, disc space narrowing, facet degenerative joint disease, no unstable findings, and possible underlying paraspinal spasm.

Right hip from June 29, 2004 documents no acute bony abnormalities.

Right knee from June 29, 2004 documents no acute bony abnormalities of the right knee at this time (non weightbearing).

MRI right knee from July 1, 2004 documents medial degenerative joint disease, no acute fractures, contusions or bone bruises; suprapatellar effusion, Baker's cyst, and possible strain patellar retinaculum.

MRI cervical spine from July 14, 2004 documents continued evidence of spondylosis.

Lumbosacral spine from July 14, 2004 documents degenerative disc disease.

MRI of the thoracic spine from July 14, 2004 was unremarkable.

Prior records regarding the left knee were reviewed through 2002.

I additionally reviewed records from Dr. Stefanovski from July 1, 2004. These reflects right knee pain and problems only. This reflects his alleged mechanism of injury. The patient was notable for good range of motion, mild effusion, and medial joint tenderness with negative x-rays. MRI as reported.

July 8, 2004 follow up, MRI positive with meniscus tear. Scheduled for surgery.

August 13, 2004, operative note and photos were reviewed. Photos were of a relatively poor quality. The operative note was clear. It is notable that the patient's examination showed early grade II degenerative changes in the kneecap. Additionally the trochlear groove that the kneecap glides in had these changes. He was considered to have fibrillated cartilaginous debris, which was suctioned out. The medial compartment was noted to have a tear of the posterior horn of the medial meniscus. Clearly Dr. Stefanovski describes this as a "degenerative horizontal type tear". He did not describe an acute tear. He did not describe blood in the knee. He did not describe significant effusion at that point in the knee. He did not describe trauma to the cartilage surfaces. This was on August 13, 2004, five to six weeks after injury. It was also notable that the patient was found to have grade III and "very small area of grade IV" changes in the medial knee consistent with arthritis. The patient had not had weightbearing x-rays prior to that time and the patient had had this finding noted on MRI just a couple of days after his acute injury.

Post surgical notes from Dr. Stefanovski document swelling and workup which was negative for deep venous thrombosis.

By September 21, 2004, the patient was doing fairly well, "no evidence of effusion". He was noted to have visual pain, but I did not see any history of objective restrictions.

On March 15, 2005, almost a six-month period had passed. Dr. Stefanovski reflects the arthritic changes in the knee and the fact that he tried cortisone to settle the knee down. I do not see a history of care in the intervening significant time period and specifically do not have further notes from Dr. Stefanovski.

Prior notes from other treatment were reviewed, including the significant pain management incurred through HealthSouth Pain Management both before and after the patient's fall. I reviewed the records from specifically July 9, 2004. It is interesting to report that he did report his injury at that time and I do not see any documented history by Dr. Rai, his long-term treating pain specialist, of significant changes in his diagnosis in general with the exception of his right knee.

Additionally reviewed were physical therapy notes.

DISCUSSION: Upon review of all of the records I have available, I would state that a few things appear to be clear.

Mr. Biebel claims a fall on June 29, 2004 injuring his right knee, back and neck. I am not aware whether this was witnessed or not. I would state that Mr. Biebel was status post a less than recovered left knee revision replacement, had documented atrophy in that knee, and he utilized a cane regularly. He would certainly be at risk for injury in general more than in the general population. The risk of falling for any reason with quadriceps atrophy and the need for a cane is significantly higher than in the general population. He states that he fell on his right knee and incurred emergency room care. I have reviewed the emergency room records, which describe a strain or sprain to the right knee and to the cervical spine. I do not see a diagnosis by a physician of a lumbosacral issue.

I do see an extensive past medical history of pain management for lumbar radiculopathy, degenerative disc disease. I do see significant records over extended visits for degenerative disc disease, neck pain, lumbosacral pain.

Mr. Biebel has an extensive preexisting history in those areas.

From the records I have available for review, it appears he saw Dr. Stefanovski for his right knee. I do not see records or complaints regarding his neck and back and *do not see a significant*

change in his pattern of neck and back chronic pain treatment at HealthSouth Pain Management by Dr. Rai.

It is clear to me that Mr. Biebel incurred no significant long-term cervical or lumbar injuries related to the fall on June 29, 2004. Indeed, it would be my contention that he did not really even fully list these pre-existing problems in his emergency room visit. I thus could not relate in any way his cervical or lumbar problems to June 29, 2004 based on total review of records and examination of the patient.

Regarding his right knee, it appears that he allegedly fell and injured the right knee. It is of interest that in the emergency room, while he had subjective pain, there was no objective evidence of an effusion at that point and only subjective findings were noted.

It is also of interest that at the point he had an MRI within a few days, Mr. Biebel had evidence of medial arthritis, which could not occur acutely. He was felt to have possible meniscal pathology and also had a Baker's cyst, which is a chronic finding.

Upon evaluation by Dr. Stefanovski surgically, it is of significance that he was not found to have acute chondral injuries to the knee similar to what he had described on the left. Indeed the right knee findings were listed as arthritic in nature.

Specifically, the meniscal tear he had resected was described as *a "degenerative horizontal type of tear". He was found to have "grade III and very small grade IV degenerative changes in his tibial plateau".*

Surgical findings also did not find sprains or sprains of the ACL, LCL, MCL. Dr. Stefanovski's surgical findings indeed would be more accurate than MRI findings.

It is my contention based on review of these records that Mr. David Biebel may have incurred some degree of a right knee sprain or strain on June 29, 2004 based on the mechanism and his alleged complaints.

At the time of evaluation in the emergency room his examination was benign with subjective findings only.

Dr. Stefanovski felt there was a small effusion. His surgical findings were clearly and concisely atraumatic and degenerative in nature. I see no evidence of hemarthrosis or a large blood collection. I see no documented history of a traumatic injury to the joint. If indeed this was considered an aggravation, one would expect especially with an MRI three days after injury to see significant chondral changes both on the right knee cartilage itself and subchondral bone edema, especially that early after injury almost mandatory for consideration of a true aggravation from an objective standpoint at all.

Notable is that by September 2004 after surgery the patient was doing well. There was a six-month period without treatment and he returns. There are significant subjective complaints and again very little objective findings noted.

The patient's examination today has significant pain to light touch, very minimal findings other than that of degeneration.

Degenerative arthrosis is common in the normal population and indeed was found at surgery and a few days after the patient's injury.

His ongoing symptoms are clearly and concisely at this point related only to degenerative arthritis and not related at all to his injury of June 29, 2004. It appears that he had a minimal injury , with minimal objective findings and indeed at surgery was found to have a degenerative meniscus tear, not an acute traumatic type tear. While Dr. Stefanovski certainly may have resected this tear to help the patient, I see no relationship directly to this tear and his fall. While he had subjective pain complaints, degenerative tears by their very nature are that – degenerative in nature. This is a very clear definition.

Given the lack of objective findings presurgically, the clear evidence of MRI findings of degeneration and degenerative meniscal tears, the surgical findings, it is my opinion that Mr. David Biebel was recovered from any and all right knee injuries from June 29, 2004 and ongoing complaints are that of degenerative arthritis. Degenerative arthritis is a very common diagnosis in the general population and specifically in a 60-year-old male who has worked for a living. Degenerative arthritis is by its nature degenerative and progressive and notable is that similar to the patient's left knee in which he was not felt to have arthritis on original x-rays, his surgical findings early on showed arthritis. He, in my opinion, incurred no degree of trauma which would change the natural history of expected progression. The patient needed arthroplasty on his other side three years ago. It would be often expect to need arthroplasty in the right knee due to natural wear and tear patterns in this time period. It is my opinion that his ongoing treatment is degenerative related.

Sincerely,

Brian F. Jewell MD

Brian F. Jewell, MD

BFJ/als/bmp